CHAPTER II – WAIVER ELIGIBILITY

2.01 Waiver Eligibility

Waiver program eligibility is established when the applicant meets all of the following eligibility criteria:

1. Meets the definition of the appropriate Waiver program target group;

2. Meets a Waiver level of care reimbursable by Medicaid;

3. Resides in an eligible living situation;

4. Meets the non-financial and financial criteria for Medicaid contained in this Manual;

5. Meets any applicable requirements for Wisconsin residency; and

6. Is determined to need Medicaid Waiver services.

2.02 BDDS Waiver Target Groups

Wisconsin residents who are to be served with one of the community Waiver long-term support programs administered by BDDS must meet the criteria that define one of the target groups listed in this Manual. These target groups have a common requirement of significant functional limitations and a need for long-term care services. The target groups include: children and adults with developmental disabilities or traumatic brain injuries, children with physical disabilities, and children with a severe emotional disturbance.

A. Developmental Disability

Persons who have a developmental disability of any age may be served by the Community Integration Program IA (CIP IA) or the Community Integration Program IB (CIP IB). Children with a developmental disability may also be served by the Children's Long Term Support Developmental Disability Waiver (CLTS). The term "developmental disability" is defined in Wisconsin Statutes in S.51.01 (5) (a). This definition includes a list of disabling conditions. Developmental disabilities are also defined in Federal Rule P.L.95-602. This definition emphasizes an individual's functioning capacity.

To meet the developmental disability target group covered by the BDDS-administered Waivers, the person must meet the federal definition of developmental disability. This

definition states that "developmental disability" means a severe, chronic disability of a person which:

1. is attributable to a mental or physical impairment or a combination of mental or physical impairments;

2. is manifested before the person attains the age twenty–two;

3. is likely to continue indefinitely;

4. results in substantial functional limitation in three or more of the following seven areas of major life activity: A) self care, B) receptive or expressive language, C) learning, D) mobility, E) self direction, F) capacity for independent living, G) economic self-sufficiency; and

5. reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

B. Physical Disability [2]

Children with physical disabilities are served by the Children's Long Term Support Physical Disability Waiver. There are situations where children with physical disabilities must be served by CIP II. Eligibility for CIP II is established when the Department determines that the child meets the criteria contained in section 2.05, below.

Physical disability is defined as a physical condition, including an anatomical loss or muscular-skeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly limits at least one major life activity of a person (see S. 15.197 (4) 2., Wisconsin Statutes).

C. Children with Severe Emotional Disturbance:

Children with severe emotional disturbances are served by the Children's Long Term Support Mental Heath Waiver. A child must meet **all** of the following criteria that define eligibility for this Waiver unless the exception applies:

1. Person is under the age of 22;

2 This definition applies only to BDDS-administered Waivers and not to COP-W or CIP II.

2. Person has an emotional disability that has persisted at least six (6) months unless the following exception applies:

   Exception: If the emotional disability has not persisted for six (6) months but the nature of the acute episode is such that impairment in functioning is likely to be evident without the intensity of treatment requested, the duration requirement is met.

3. Person's current emotional disability is expected to persist for a year or longer.

4. The child must have an emotional and/or behavioral condition that has been diagnosed by a board-certified psychiatrist or clinical psychologist (Ph.D) under the classification system in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

5. The child must have either specific psychiatric symptoms or significant functional impairments in two of the following capacities noted below, and at a level that would place the child at risk for hospitalization. Functional areas include: self care, community involvement, social relationships, family relationships, and school or work.

6. The child is receiving services from **two or more** of the following service systems: Mental Health, Special Education related to emotional needs, Juvenile Justice, Child Protective Services (voluntary or involuntary), and Social Services or **one system only**, if the intensity of treatment needed is **three (3) hours or more** per week of mental health services.

D. Brain Injury:

Children and adults with brain injuries are served by the Brain Injury Waiver (BIW). Children with brain injuries can also be served under the DD Waivers (CIP 1A, CIP 1B and CLTS-DD) since the on-set of injury would be prior to age 22 years. Brain injury is defined in S.51.01 (2g)(a) of the Wisconsin Statutes as any injury to the brain, regardless of age of onset, whether mechanical or infectious in origin including brain trauma, brain damage and traumatic brain injury, the result of which constitutes a substantial impairment to the individual and is expected to continue indefinitely. Brain injury includes any injury to the brain that is vascular in origin that is sustained by the person prior to attaining age twenty-two. Brain injury does not include alcoholism, Alzheimer's disease or a like irreversible dementia. When the applicant is a child who has a traumatic brain injury the applicant may apply to any Waiver that serves persons who have a developmental disability.

The following chart summarizes this material:

BDDS WAIVER TARGET GROUPS

WAIVER PROGRAM	CIP 1A/CIP 1B	BIW	CLTS-DD	CLTS-SED	CLTS-PD
Target Group	✓ Persons of any age with a developmental disability who meet the Federal definition	✓ Persons of any age with a brain injury regardless of age of onset	✓ Persons under age 22 with a developmental disability who meet the Federal definition	✓ Persons under age 22 with a severe emotional disturbance	✓ Persons under age 22 with a physical disability

2.03 Waiver Services for Persons with Severe and Persistent Mental Illness

Except in the cases of children as described in 2.02-C above, persons with severe and persistent mental illness must also have either a developmental disability, physical disability or a traumatic brain injury to be served by one of the BDDS-administered Waivers. These individuals must meet all other eligibility criteria as well including eligibility for appropriateness for admission to an ICF-MR at a level of care reimbursable by Medicaid. Persons with developmental disabilities who meet the eligibility criteria for admission to an institution for medical disease (IMD) are not eligible for these community Waiver programs while they reside in the IMD.

2.04 Change of Waiver; No Active Treatment (NAT) Determination

A. Definition and Application of NAT Determination

Medicaid Waiver services may continue for persons in CIP 1A, CIP 1B and BI Waivers when they reach age 65 unless the person's condition changes and the participant receives a "No Active Treatment (NAT) determination. When such a determination is made, the person loses eligibility for all BDDS Waivers including the CIP 1A, CIP 1B and BI Waivers. These individuals may be served in COP-W or CIP II. This provision implements an exception to federal regulations that require persons with a developmental disability to receive active treatment. If a Waiver participant has medical needs that are of such a severe and chronic nature as to require Skilled Nursing Facility (SNF) level nursing care or the person has a physical and mental incapacitation due to advanced age, and the person's needs are similar to

those of geriatric nursing home residents, he/she qualifies for the NAT determination and is not eligible for continued participation in the BDDS-administered Waivers.

Any one of the following criteria aid in the determination of when a NAT rating is appropriate:

1. Persons who are elderly (generally over 65 years of age), with a combination of factors which would indicate the individual has reached his or her maximum potential and would no longer benefit from active treatment. Such factors may include:

    a. More than ten (10) years in a nursing facility;

    b. Degenerative health status;

    c. Discharged or transferred from ICF/MR facility after age 55-60;

    d. Has been discontinued from any service due to determination that they s/he reached maximum benefit;

    e. Adaptive behavioral assessments by community service boards and other professionals (QMRPs, psychologists) indicate that the individual has reached his/her maximum potential and the major portion of care is maintenance of present skills and no further growth is expected;

2. Terminal illness;

3. A person with related condition, such as epilepsy, brain damage, autism or cerebral palsy, who is not mentally retarded and is competent to handle his or her own affairs.

B. Procedures for requesting a NAT Determination

The procedures used to request a NAT determination are:

1. CIP II or COP-W applicants have their care level assigned by either the Bureau of Long Term Support or The Management Group.

2. Institution staff identify someone they believe may not require active treatment.

Determinations of "No Active Treatment" will be indicated on plan approval letter for CIP II and COP-W participants.

2.05 Medicaid Non-Financial Eligibility Requirements

Certain non-financial eligibility determinations for Medicaid are made by the county's Department of Social Services, Human Services Department, or Economic Support Agency (ESA.) They include the determination of Wisconsin residency and United States citizenship, disability (in some instances) and a need for Waiver program services.

A. Residency and Citizenship:

Persons using these Waivers must be legal residents of Wisconsin and United States citizens.

B. Disability:

Medicaid Waiver participants are required to have a disability determination. The Disability Determination Bureau (DDB) in the Division of Health Care Financing makes some of these determinations. In other cases this determination is made by the Social Security Administration. When the determination is made by DDB, the ESA or DDB may make a **presumptive disability** determination. A person with a presumptive disability assignment is considered eligible until a final disability determination has been completed. If a presumptive disability determination is later reversed by DDB, the person will become ineligible for Medicaid Waiver program participation and termination must occur. All rules and policy affecting "notice of decision" apply in these cases. Medicaid benefits received during the period of presumptive eligibility are not recoverable.

C. Need for Medicaid Waiver Program Services:

Persons who have been determined to meet the non-financial and functional eligibility criteria for Waiver participation but who do not need Waiver program services are not eligible for Medicaid using the special Waiver program eligibility criteria. In those instances where Support and Service Coordination is the only service funded by the Waiver program there must be evidence that the participant is receiving other long-term support services. Those services may be funded by another payment source, may be provided by family members or another informal support provider, or may be provided intermittently. In such circumstances the Waiver agency must provide assurance that all of the assessed needs of the participant are met and that Support and Service Coordination services are justified.

2.06 Level of Care

A. Level of Care (LOC) for CIP1A and CIP 1B Waivers

In order to be eligible, CIP IA and CIP IB participants must qualify for a DD level of care (LOC) reimbursable by Medicaid in an ICF-MR at a level of DD-3 or higher as indicated on the Title XIX Level of Care (LOC) Determination Form. For CIP IA only, the State Centers will complete the initial LOC Form which includes Forms DDES 2256 and 2256a, Parts A and B, and indicate the current LOC rating. Division of Disability and Elder Services staff in the Bureau of Quality Assurance (BQA) rate all other CIP IA and CIP IB LOC forms. In addition, if COP funds are used to serve the person in any way, a COP Functional Screen rated at level 1 or level 2 is also required for those CIP IA or CIP IB participants who are classified as "diversions" or "replacements" by BDDS and reported as such. Any county using the Long Term Care Functional Screen (LTCFS) may use a copy of that screen to replace previous level of care form requirements.

Grand-father Clause for ICF/MR 4 LOC

Individuals with developmental disabilities with a level of care of ICF-MR-4 (also known as DD-4), ICF-3 or ICF-4 who were admitted to a Medicaid-certified health care facility on or before November 1, 1983, and have resided continuously since that time in a Medicaid- certified health care facility are "grandfathered" into the Medicaid program for reimbursement of their ICF-MR-4, ICF-3 or ICF-4 LOC.

Waiver participants considered "relocated" may elect to return to a nursing home or institution and have Medicaid pay the cost of their care, the same as if they had remained in the nursing home or institution in grandfathered status. The Waiver participant does not lose grandfather status in the community provided that Waiver services continue. Participants maintain their grandfather status just as they would in the nursing home or institution.

B. Level of Care for BI Waiver

In order to be eligible for the BI Waiver, participants must qualify for a level of care (LOC) reimbursable by Medicaid in a nursing home or eligible for post-acute rehabilitation institutional care as indicated on the Medicaid Level of Care (LOC) Determination Form. For BIW only, the Bureau of Developmental Disabilities Services determines BIW level of care from the LOC Form. This form includes DDES Forms 2256 and 2256a, Parts A and B. The Bureau also needs the applicant's individualized service plan and documentation of a brain injury. Documentation from the original brain injury hospitalization that states the date of onset, etiology of the brain injury, and how the person's functional status is impaired due

to the brain injury is also needed for the initial LOC determination. In addition, if any COP funds are to be used, a COP Functional Screen is also required as with CIP 1A/B.

C. Level of Care for CLTS

In order to be eligible for any of the CLTS Waivers participants must qualify for either a DD, PD or SED level of care (LOC) reimbursable by Medicaid in a comparable institutional setting. The Level of Care (LOC) Determination process for children requires the completion of the application for children under the Katie Beckett Program, as well as all related documentation from families.

The Katie Beckett Program application forms include: the Application Form, either DDES-582 for children with physical and or developmental disabilities, or DDES-582-S for children with severe emotional disturbance-SED, Authorization to Disclose Information to the Disability Determination Bureau (HCF-14014), Confidential Information Release Authorization (HFS-9 version AA), Statement of Child's Income and Assets (DSL-586), and Health Insurance Information form (DES-2096). Directions related to these forms can be found in Form DDES-585B. Any county involved in the testing of the Children's Long Term Support Functional Screen (CLTSFS) may use a copy of that screen to replace the application from the level of care forms requirements noted above. The other application materials are required in addition to the CLTSFS. Completed materials should be submitted to the BDDS Central Office to the attention of the Katie Beckett Program with an indication that you are requesting a CLTS Waiver LOC. Children will be assigned the appropriate LOC, and where applicable the LOC may be appropriate for more than one Waiver so that the county will be able to choose which Waiver is most appropriate to the child's needs.

2.07 Eligible Living Situations for CIP1 A/B, BIW, and CLTS

The term "reside" as used in this section means "a permanent living arrangement that does not include places where the Waiver participant stays on a temporary basis including places used as sites for respite care." See the definition of Respite Care in Chapter 4 for the settings that are permitted for the provision of respite care.

A. Allowed Living Arrangements for Permanent Residence

Waiver participants served in the CIP 1A, CIP 1B and BI Waivers must permanently reside in a natural setting in the community including a house, apartment, condominium, boarding house, or in one of the following regulated settings:

- an adult family home certified for 1 or 2 beds
- a licensed children's foster home
- a licensed children's treatment foster home

- an adult family home licensed for 3 or 4 beds;
- a CBRF licensed for 5-8 residents if a variance has been granted; or
- a dormitory

Waiver participants served in any of the three CLTS Waivers must permanently reside with their natural or adoptive families in a natural setting in the community including a house, apartment or condominium or in one of the following regulated settings:

- A licensed children's foster home; or
- A licensed children's treatment foster home.

B. Prohibited Living Arrangements for Permanent Residence

Except as provided in the service definition of Respite Care in Chapter IV, a Waiver participant may not receive funding for Waiver-covered services if he/she resides in:

- a hospital;
- an institution for mental disease (IMD);
- any licensed nursing facility (SNF, ICF);
- an intermediate care facility-mental retardation (ICF-MR) including any of the Wisconsin Centers for the Developmentally Disabled; or
- a jail or prison.

C. Prohibited Living Arrangements for Children Under Age Eighteen (18)

Except as provided in the service definition of Respite Care in Chapter IV, below, a Waiver participant who is a child may not receive funding for Waiver-covered services if he/she resides in:

- a group home for children licensed for 5-8 beds; or
- a Residential Care Center (formerly known as Child Caring Institutions (CCI) of any size.

2.08 Waiver Participant Moves between Counties

This section addresses responsibility of the two counties for funding Waiver services when a participant moves from one county to a different county. It also describes the process used to accomplish the transition of funding between the two counties. In this chapter, the two counties are referred to as the "sending county," which is the original county from which the participant moved and the "receiving county," the county to which the participant moved.

Policies concerning funding responsibility are intended to support the policy that the Waiver is portable across county lines. An eligible Waiver participant who has begun receiving services has a right to continuity of services and freedom of choice while residing in Wisconsin. This means that an eligible Waiver participant should be able to move anywhere in Wisconsin without losing eligibility to receive

Waiver-covered services. Services may not be reduced or terminated solely because the participant has moved to a different county. There are administrative consequences to the two counties involved in a participant move related to program responsibility and funding responsibility.

A. Program Responsibility:

When a CIP IA, CIP IB, BIW or CLTS participant moves to a different county, the sending county is required to continue to provide or assure a level of services and supports sufficient to address the person's needs until the receiving county is able to assume responsibility for support and service coordination. The sending county also continues to be responsible for assuring the individual's health and safety. The sending county must also revise the participant's individual service plan to reflect changes in setting, provider and/or services. The sending county must also contract with and monitor all service providers used, ensure these providers meet Waiver requirements and standards, and continue to coordinate and monitor services. For the entire period the sending county is funding services, this Waiver participant is considered to be the responsibility of the sending county for all purposes associated with the Waiver program including HSRS reporting. If the move is of significant distance (either more than 2 hours drive or further than 100 miles from the location of the service coordinator) the ISP must also address how participant health and safety will be monitored and assured by the sending county.

B. Funding Responsibility:

1. When a person voluntarily moves to a new county and establishes legal residence there (physical presence and intent to remain), the receiving county is required to provide funding for the level of services and supports sufficient to address the person's needs identified in the assessment and service plan if and when it has the necessary resources to accomplish this. Waiver participants or the sending county have the responsibility to notify the receiving county, with as much advance notice as possible, of their plans to move. The receiving county must respond to the move and fund the plan thirty days after receiving notice of the move from either the participant or the sending county.

   If the receiving county lacks all/any of the resources to finance the plan, it must place the person on its waiting list. The sending county is required to continue to fund that portion of the plan that the receiving county is not able to fund until the receiving county has resources to fund the plan.

2. If the Waiver participant who moved is next on the receiving county's waiting list and some but not all of the resources needed to fund the plan become available, the receiving county shall use those resources to partially finance the plan, with the sending county continuing to fund the remaining portion of the person's plan. Once the receiving county has begun to fund the Waiver participant even in part, the receiving county is then obligated to take primary program

responsibility for the Waiver participant. The sending county is obligated to continue to finance the portion of the plan that the receiving county is unable to finance until the receiving county has identified all of the resources needed. After a move and after the receiving county initiates funding even some of the services, any reductions in service cost will be applied to the sending county's portion of the plan costs while any increases will be the responsibility of the receiving county. After the transfer of program responsibility to the receiving county, the sending county is not obligated to respond to increased needs for funding. These responsibilities fall to the receiving county.

3. Effective January 1, 2004, when a Waiver participant moves from a sending county to a receiving county, the sending county is required to transfer the person in the same type of slot he/she was originally assigned when he/she first entered the Waiver program.

   The transfer of the slot by the sending county may be delayed at the discretion of the sending county if, after the move, the cost of the Waiver participant's updated plan is less than the per diem associated with the slot that would be transferred. Under this circumstance, the sending county is assumed to be using the balance of the per diem to fund services for other Waiver participants. The sending county may retain the slot until December 31 of the year in which the move took place if the sending county fully funds the plan for that period of time. The receiving county must take program responsibility for the Waiver participant under these circumstances. Effective January 1 of the next year, the slot the participant was originally assigned must be transferred from the sending county to the receiving county. The sending county may also complete the transfer of the slot at ant time during the year of the move.

   If any state Medicaid funds are associated with a slot when the slot is transferred, the receiving county shall finance the service plan up to the per diem rate of that slot at the time of transfer. If the receiving county lacks the funds to fully finance the service plan, the provisions of Chapter 1 concerning waiting lists apply. Under this circumstance, the provisions in this chapter concerning program responsibility also apply. This means that the receiving county must assume program responsibility for the participant.

   The rationale for this policy is based on the fact that the Waiver programs have, from their inception, dictated money following the person. In addition, when the person was first approved for Waiver participation, the type of slot assigned usually had some relationship to the level of need. CIP 1A participants relocated from State Centers brought with them a higher per diem for the county that originally served them. This policy is intended to keep the association of the original level of funding with the person so that the receiving county receives the same advantage as the sending county had enjoyed. This policy is necessary because BDDS permits counties to make slot switches so they fully qualify for as much state funding for Medicaid match as possible.

4. When a member of a Family Care CMO moves to a CIP1 A/B, BIW, CLTS (for participants from age 18 – 22 years) county and the new county of residence is able to immediately provide and fund Waiver program services, the member will be disenrolled from the CMO in the Family Care county of origin. To assure the continuity of service provision, the CMO county should contact the new county to facilitate the application for Waiver program services and to assure there is no lapse in Medicaid coverage. The CMO will transfer level of care, assessment and service information to the new county and ensure, to the extent possible, disenrollment from Family Care coincides with the start of Waiver services in the new county.

   If a CMO member moves to a CIP 1A/B or BIW county where there is a list of applicants awaiting further consideration for Waiver services for which the member is eligible, **and** the member has been continuously enrolled in the CMO for at least six (6) months prior to the date of the move, he/she will be disenrolled from the CMO. The state will then temporarily transfer funds to the appropriate Waiver in order for the new county to serve the former Family Care member. At the time the new county is able to fund services for the former CMO member, the new county shall notify the Department and begin to fund services under the county's CIP 1 A/B, or BIW Waiver program or COP allocation.

   If the CMO member moves to a CIP I A/B, BIW, or CLTS (for participants ages 18 –22 years) county but has not been enrolled in the CMO for at least six (6) months he/she loses eligibility for Family Care and is disenrolled. The state will not transfer funds to serve the former member in the CIP 1A/B, BIW, or CLTS (for participants ages 18 – 22 years) county and the person cannot be served by the new county until COP or Waiver funds are available. The CMO will notify the member that disenrollment will occur and inform her/him that funding for services will not be transferred to the new county. The CMO shall also inform the former member that application for long-term care services must be made in the new county. The CMO should facilitate contact with ESS and Waiver program contact persons in the new county and coordinate the transfer of financial, level of care, assessment and service information to the receiving county.

   When a CIP 1 A/B, BIW, or CLTS (for people from 18 – 22 years of age) Waiver participant moves to a Family Care county the Waiver Care Manager or Support and Service Coordinator should contact the resource center and CMO in order to coordinate continuity of care so there is no lapse in coverage. The Waiver Care Manager or Support and Service Coordinator will ensure eligibility, assessment and service information is transferred to the Family Care county. The counties shall coordinate efforts to the extent possible so that the Waiver closing date coincides with the start of services in the Family Care county.

   Since Family Care does not serve children, provisions of this section do not apply to the CLTS Waivers for participants younger than 18 years.

2.09 Denial of Participation and Termination

A. Reasons for Denial of Participation

An otherwise Medicaid-eligible applicant must be denied Waiver program participation if his or her assessment and service plan indicates that health and safety cannot be assured in the community setting.

Other conditions under which an otherwise Medicaid-eligible applicant/participant may be denied participation in the Waiver and/or have their participation terminated include:

1. When the estimated cost of services to the Medicaid Waiver services plus services claimed under the Medicaid state plan would cause average program expenditures for the Department to exceed its cost effectiveness limit for the specific Waiver in which the person is enrolled. Denial for this reason requires Department action and approval. This policy may not be used to deny someone the right to apply for any Waiver.

2. Failure to meet basic financial and non-financial eligibility criteria, level of care criteria or residing in a non-Waiver allowable living arrangement at initial application, annual recertification or at any time while participating in the Medicaid Waiver programs may result in termination from the Waiver program.

B. Notification of Termination

If the applicant is denied Waiver participation or a current participant is proposed to be terminated from Waiver participation, the participant must be given written notice at least ten (10) calendar days prior to the effective date of the proposed action, must be informed of the right to appeal the proposed action and must be given access to a fair hearing. When such notice is required, the notice shall clearly state what action the agency intends to take, the effective date proposed for that action, the reason for the action and the specific regulation being applied to support the county's action. The notice shall also explain that if a hearing is requested, Medicaid Waiver program funding will be continued until the issue is resolved via the fair hearing. The participant has 45 days from the effective date of the action to appeal the agency action. County agencies must follow the provisions in Chapter VIII of this manual governing Participant Rights.

When a fair hearing is requested due to a termination or reduction in Medicaid Waiver program services the process provided in Chapter 227 Wisconsin Statutes is used. When a Chapter 227 fair hearing is requested by the participant or his/her authorized representative before the effective date of reduction or termination of service or participation, Medicaid Waiver program funding will continue uninterrupted until the date of the hearing examiner's decision. In these circumstances, if the hearing officer's decision does not uphold the participant's position, Medicaid Waiver program funding will terminate on the date of the hearing decision.

If a Chapter 227 hearing is not requested prior to the effective date of reduction or termination of service specified by the county, Waiver program funding will be discontinued on the effective date of the notice. Funding may be restored by the hearing officer or the agency retroactive to the date an incorrect action was taken.

Use of the Chapter 227 process does not preclude the use of the county's grievance process under S. 51.61 Wis. Stats. and HFS 94 if the participant wishes to file such a grievance. Procedural requirements of that rule must be adhered to if such a grievance is filed.